

# ITS-SIDS Alternative Sleep Position/Use of Wedge Health Care Professional Waiver

This must be completed by a physician, nurse practitioner, or physician's assistant – 10A NCAC 09.0606

This form must be used for an infant aged six months or less. This form may be used for an infant older than six months.

## Parent/guardian completes this section.

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age in months \_\_\_\_\_

Parent/guardian name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Email \_\_\_\_\_

## Child's primary health care professional completes this section.

Health care professional's name \_\_\_\_\_

Name of practice \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_ Fax number \_\_\_\_\_

Email \_\_\_\_\_

N.C. Child Care Law requires that child care facilities place all infants on their backs to sleep. At the advice of the infant's primary health care professional, the parent/guardian may authorize the facility to place their infant in an alternative sleep position or to use a wedge for medical reasons. The center shall retain the waiver in the child's record as long as the child is enrolled at the center.

Medical reason for alternative sleep position or use of wedge for infant named above \_\_\_\_\_

The recommended sleep position for this infant is \_\_\_\_\_

Specific placement and directions for use of wedge: \_\_\_\_\_

Effective Dates of Waiver: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Care Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_

## Parent/guardian signs this statement.

I, as the parent or guardian of the above mentioned child, do hereby release and hold harmless the child care facility listed below, its officers, directors, and employees, from any and all liability whatsoever associated with harm to my child due to Sudden Infant Death Syndrome (SIDS). I affirm and acknowledge that the child care facility named above gave me information about SIDS. I authorize this child care facility and its employees to place my child in the alternative sleep position/use a wedge as described above at the recommendation of my child's primary health care professional.

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

## An authorized facility representative of the child care facility completes this section.

Name of Child Care Facility \_\_\_\_\_ ID # \_\_\_\_\_

Facility Representative's Signature \_\_\_\_\_ Date \_\_\_\_\_

